

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADULT DAY SERVICES PROGRAM RE-APPLICATION
DIVISION OF LICENSING AND REGULATORY SERVICES
COMMUNITY SERVICES PROGRAMS
11 STATE HOUSE STATION
AUGUSTA, ME 04333
(207) 287-9250
FAX: (207) 287-9252

Program Name: _____ Telephone: _____

Mailing Address: _____

Site Address: _____

E-Mail Address: _____

Owner: _____ EIN# or SSN: _____

Administrator: _____ SSN: _____

Social ☐ Day Services ☐ Current # of Consumers licensed for: _____
Adult Day Health ☐ Night Program ☐ Request Increase/Decrease in # of
Adults by: _____

Days/Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Changes to the program and effective dates, including form revisions (attach if any) since last license:

Physical plant changes: _____

Other changes: _____

If Program has been granted a waiver, do you wish to continue this waiver? Yes ☐ No ☐

If so, please indicate Regulation # and reason for continuing waiver: _____

Have you (Applicant and/or Administrator) ever:

	YES	NO
Been convicted of a crime?	_____	_____
Been an inpatient in a mental health facility?	_____	_____
Been treated for drug/alcohol abuse?	_____	_____
Been investigated for child/adult abuse, neglect, or exploitation?	_____	_____
Had a license / application to operate a residential care facility revoked / denied / placed on conditional status?	_____	_____

If you (Applicant and/or Administrator) answered "YES" to any of the above questions then please explain and state persons involved.

The applicant certifies that information contained in this reapplication is true and correct to the best of their knowledge. The Department of Health and Human Services reserves the right to determine the ability of the applicant for re-licensure.

I, _____, being duly authorized to assume responsibilities for the operation of the program herein described, do hereby apply for re-licensure to operate the program and do agree to assume responsibility that the Adult Day Services Program will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, M.R.S.A. §7801.

Include a current Certificate of Insurance for liability and property damage and vehicle Liability (if transportation is provided by the program).

Send a non-refundable application fee made payable to Treasurer, State of Maine and mail to the above address prior to the expiration of your current Adult Day Services Program License.

Check the amount enclosed:

- ☐ \$10 (up to 10 consumers)
- ☐ \$20 (11-20)
- ☐ \$30 (21-30)
- ☐ \$40 (31-40)
- ☐ \$50 (41 or more)

FOR OFFICE USE ONLY

FEE
RECEIVED _____

CHECK # _____

Applicant signature: _____ Date: _____

Title: _____